MassHealth

Billing Guide for Paper Claim Form No. 9

Executive Office of Health and Human Services
MassHealth
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Introduction

The following information describes in detail how to bill on the paper claim form no. 9. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for Claim Form No. 9.

General Instructions for Submitting Paper Claims

Claim Form No. 9

The following providers must use claim form no. 9 (Request for Payment-Medical Services Claim) when submitting paper claims to MassHealth:

- abortion clinics;
- adult day health providers;
- adult foster care providers;
- audiologists;
- chiropractors;
- community health centers;
- day habilitation providers;
- durable medical equipment providers;
- early intervention providers;
- family planning agencies;
- group adult foster care providers;
- hearing instrument specialists;
- home care corporations (elderly waiver);
- home health agencies;
- hospice providers;
- independent clinical laboratories;
- independent living centers;
- independent nurses;
- mental health clinics;
- Municipal Medicaid providers;
- ocularists;
- opticians;
- optometrists;
- optometry schools;
- orthotics providers;
- oxygen and respiratory therapy equipment providers;
- personal care agencies;
- personal care attendant (PCA) fiscal intermediaries;

General Instructions for Submitting Paper Claims (cont.)

- podiatrists;
- prosthetics providers;
- psychiatric day treatment providers;
- psychologists;
- rehabilitation centers;
- renal dialysis centers;
- speech and hearing centers;
- sterilization clinics;
- substance abuse treatment programs;
- targeted case management programs; and
- therapists.

To obtain supplies of claim form no. 9, submit a request to MassHealth at the address found in Appendix A of your MassHealth provider manual.

Entering Information on Claim Form No. 9

Follow these guidelines when filling out the claim form.

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY format.

  Example: For a member born on February 28, 1960, the entry in Item 11 (Date of Birth) would be as follows.

022860

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, § 20) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the billing regulations in Subchapter 3 of your MassHealth provider manual.

Since the 90-day requirement applies to each claim line, the claim form must be received within 90 days from the earliest date of service on the form.

All services listed on a single claim line must have been provided in the same fiscal year. That is, if you are allowed to submit consecutive dates of service on a single claim line (that is, "from and thru" billing), dates of service from the months of June and July must never appear on the same claim line.

General Instructions for Submitting Paper Claims (cont.)

For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

Claims for Members with Other Health Insurance Coverage

Special instructions for submitting claims for services furnished to members with health-insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your MassHealth provider manual for contact information. Additional information is also available in Subchapter 5 of your provider manual.

Where to Send Paper Claim Forms

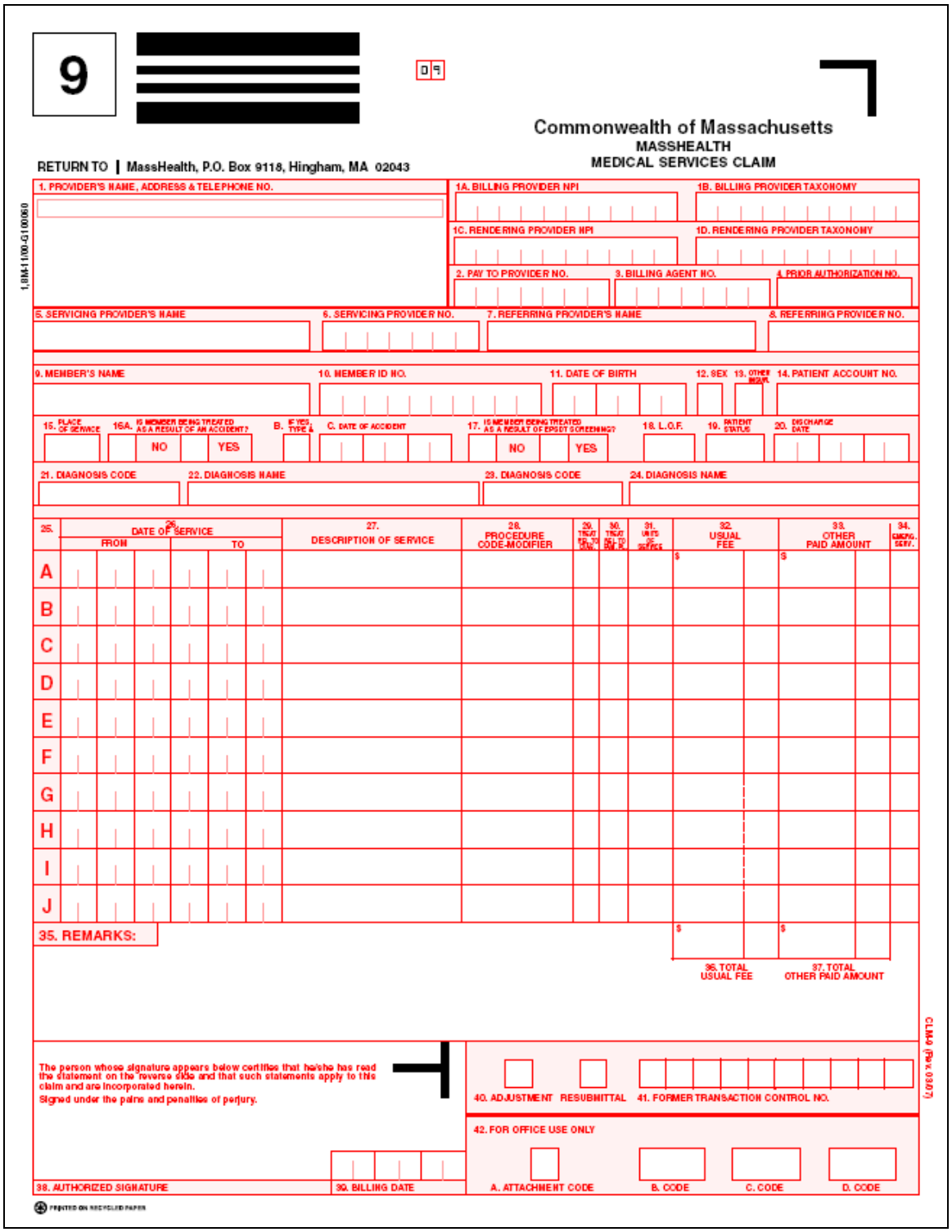
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete claim form no. 9, contact MassHealth Customer Service. Please refer to Appendix A of your provider manual for all MassHealth Customer Service contact information.

Item-by-Item Instructions for Claim Form No. 9

A sample claim form is shown below. Following this sample are completion instructions for each field on claim form no. 9. Many types of providers use claim form no. 9 to bill MassHealth for services. Complete each field as instructed for your provider type.



Item-by-Item Instructions for Claim Form No. 9 (cont.)

Item No.	Item Name	Description
1	Provider's Name, Address & Telephone No.	Enter the provider's name, address, and telephone number.
1A	Billing Provider NPI	Enter your billing (pay-to) NPI.
1B	Billing Provider Taxonomy	Enter the taxonomy code applicable for the billing (pay-to) NPI only if instructed to do so by MassHealth.
1C	Rendering Provider NPI	If the NPI entered in Item 1A is for a group practice organization, enter the rendering (servicing) NPI. *Certified independent laboratories:* If the laboratory name entered in Item 5 is not a MassHealth provider, enter the number "9999990."
1D	Rendering Provider Taxonomy	Enter the taxonomy code for the rendering provider only if instructed to do so by MassHealth.
2	Pay to Provider No.	Leave this item blank.
3	Billing Agent No.	If this form is being prepared by a billing agent, enter the seven-digit number assigned to the agent. If one was not assigned, leave this item blank.
4	Prior Authorization No.	Enter the six-character prior-authorization (PA) number assigned by MassHealth, if applicable. Refer to MassHealth regulations and Subchapter 6 of your MassHealth provider manual to determine if any services you provide require PA.
5	Servicing Provider's Name	*Certified independent laboratories:* If the specimen was referred to another laboratory, enter the name of the testing laboratory. *All other providers:* Leave this item blank.
6	Servicing Provider's No.	Leave this item blank.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

7	Referring Provider's Name	*For members enrolled in the PCC Plan:* Enter the name of the member's PCC. *For radiology services for members not enrolled in the PCC Plan:* Enter the referring provider's name. *For all other members:* Leave this item blank.
8	Referring Provider No.	*For members enrolled in the PCC Plan:* Enter the PCC's seven-digit referral number. This referral number can be obtained by contacting the PCC before providing the service. PCC names and telephone numbers are available from the Recipient Eligibility Verification System (REVS). Certain services do not require a PCC referral. Refer to 130 CMR 450.118(J)(2) for a list of services that do not require a PCC referral. *For radiology services for members not enrolled in the PCC Plan:* Enter the seven-digit MassHealth provider number of provider requesting the service. If the provider number is unknown, enter "9999990." *For all other members:* Leave this item blank.
9	Member's Name	Enter the name of the member receiving services.
10	Member ID No.	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member ID on the temporary MassHealth card may include an asterisk as the 10th character.
11	Date of Birth	Enter the member's date of birth in MMDDYY format.
12	Sex	Enter an "X" in the appropriate box to indicate the member's gender.
13	Other Insur.	Enter an "X" if the member is covered by other health insurance.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

14	Patient Account No.	Enter the patient account number, if one has been assigned by the provider. If one has not been assigned, enter the member's last name.
15	Place of Service	Enter the code from the list below that describes the place where the service was provided. 01 - office, facility, business location 02 - member's home 03 - inpatient hospital 04 - outpatient hospital 05 - emergency department 06 - nursing facility 07 - rest home 08 - freestanding ambulatory surgical center 09 - homeless shelter 10 - school-based health center 99 - other location
16A	Is Member Being Treated As a Result of an Accident?	Check the appropriate box to indicate whether or not the member is being treated as a result of an accident.
16B	If Yes, Type	If Item 16A is checked "Yes," enter the code from the list below that describes the type of accident. 1 - Automobile-related accident 2 - Employment-related accident 3 - Other type of accident
16C	Date of Accident	If Item 16A is checked "Yes," enter the date on which the accident occurred in MMDDYY format.
17	Is Member Being Treated As a Result of EPSDT Screening?	Enter an "X" in the box labeled "Yes" if the member is under 21 years of age and the services were provided as part of a well-child visit in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule (see Appendix W of your MassHealth provider manual) or as a result of an EPSDT referral. If the treatment is not related to an EPSDT screening or a well-child visit provided in accordance with the EPSDT Schedule, or if the information is unknown, enter an "X" in the box labeled "No."

Item-by-Item Instructions for Claim Form No. 9 (cont.)

18	L.O.F.	Leave this item blank unless otherwise noted. *Psychiatric day treatment providers:* Enter the member's three-digit level-of-function (LOF) score, computed from the Framingham Functional Assessment Scale.
19	Patient Status	Leave this item blank unless you are providing service as a hospice provider, psychiatric day treatment provider, or therapist, and you have discharged the patient, or as a home health agency. The valid codes are: 01 - discharged to home or self-care (routine discharge) 02 - discharged to acute inpatient hospital (short-term) 03 - discharged to skilled nursing facility (SNF) 04 - discharged to intermediate care facility (ICF) 05 - not part-time or intermittent; medically necessary; alternative more costly 06 - discharged to home under care of home health agency 07 - left against medical advice 08 - Not intermittent; physician documentation of medical necessity in excess of 21 days 09 - occupational therapy only 10 - discharged to chronic/rehabilitation hospital 11 - discharged to psychiatric inpatient hospital 12 - discharged to rest home 13 - discharged to community ICF/MR 14 - discharged to state school ICF/MR 15 - discharged to community residence 21 – deceased 99 - other *Hospice providers, psychiatric day treatment providers, and therapists:* If the member was discharged from your care, select from the following codes to indicate the patient's discharge status. 01, 02, 03, 04, 06, 07, 09, 10, 11, 12, 13, 14, 15, 21, or 99.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

19	Patient Status (cont.)	*Home health agencies:* For members who qualify for both Medicare and MassHealth, providers should generally bill Medicare for services provided, unless an exception is documented in the member's medical record. If an exception to this requirement is noted, enter the corresponding code from the list below. Providers must submit the Medicare Determination/Explanation of Benefits (EOB) to MassHealth within 10 days of receiving notification of a denial from Medicare. Please select from the following patient status codes, as applicable: 01, 02, 03, 04, 05, 06, 07, 08, or 09. *For members with other insurance:* For members who qualify for both MassHealth and commercial insurance, providers should generally bill the commercial insurer for services provided and indicate the reason the commercial insurer has denied service coverage. Providers must submit a copy of the EOB to MassHealth within 10 days of receiving notification of denial from the insurer. Please select from the following patient status codes as applicable. 01, 02, 03, 04, 05, 06, or 07
20	Discharge Date	Leave this item blank unless you are providing service as one of the applicable provider types. *Home health agencies:* If member has been hospitalized during the 30 days preceding the date of service, enter the most recent discharge date. *Hospice providers, psychiatric day treatment providers, and substance abuse treatment programs:* If the member was discharged from the program, enter the date of the discharge in MMDDYY format. If the member was not discharged, leave this item blank.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

21	Diagnosis Code	Enter the ICD-9-CM diagnosis code for the primary condition, if applicable. If there is a fourth or fifth digit, it is a required part of the code. Do not delete leading zeros, or add trailing zeros.
22	Diagnosis Name	Enter the description of the diagnosis code entered in Item 21.
23	Diagnosis Code	Enter the ICD-9-CM diagnosis code for any additional condition that has been treated, if applicable.
24	Diagnosis Name	Enter the description of the additional diagnosis code entered in Item 23, if applicable.
25		Each letter (A-J) refers to one of the 10 claim lines contained on the claim form. This letter will appear as the last character of the claim's transaction control number (TCN) listed on the remittance advice (RA).
26	Date of Service From/To	Enter the date the service was provided in MMDDYY format. *For a single date of service:* In "From," enter date the service was provided in MMDDYY format. Leave "To" blank. *For consecutive dates of service:* In "From," enter the first date of service. In "To," enter the last date of service. *Durable medical equipment and oxygen and respiratory therapy equipment providers:* *For monthly rentals:* Enter the last date of the monthly rental period in "From." Leave "To" blank. Use a separate claim line for each monthly rental period. *For substitute rentals:* Enter the date of service in "From"; leave "To" blank. Use a separate claim line for each rental day. *For purchases and repairs:* Enter the date when the service was furnished in "From." Leave "To" blank.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

26	Date of Service From/To (cont.)	Use a separate claim line for each monthly rental period. *Early intervention providers:* *For assessments:* Enter the date the assessment was completed in the "From" column. In Item 31, enter the total number of 15-minute units spent on the assessment, regardless of the date. *For all other early intervention services:* Follow the instructions given in the general description.
27	Description of Service	Enter a brief description of the service provided. *Durable medical equipment providers:* Enter a brief description of actual acquisition costs, if applicable.
28	Procedure Code-Modifier	*Municipal Medicaid providers:* Municipal Medicaid providers should refer to relevant Municipally Based Health Services Provider bulletins to determine the correct service code. *All other providers:* Enter the service code that corresponds to the service provided. See Subchapter 6 of the applicable provider manual for a list of payable service codes. When billing for a service code that requires a report, attach a copy of that report to the claim form. For certain services, a two-character modifier must be entered after the service code to fully describe services. Add the applicable modifier to the end of the service code.
29	Treat Rel. to Diag.	Leave this item blank if a diagnosis code is not entered in Item 23. If you have entered a diagnosis code in Items 21, 22, 23, or 24 above, enter the code that indicates the relationship of the treatment to the diagnosis, if applicable. 01 - relates to diagnosis code in Item 21 02 - relates to diagnosis code in Item 23

Item-by-Item Instructions for Claim Form No. 9 (cont.)

30	Treat Rel. to Fam. Pl.	Enter an "X" if services are related to family planning.
31	Units of Service	Enter the number of units for the service provided. When billing for consecutive days of service, enter the total number of days within the billing period. When billing for nonconsecutive dates of service, enter "1" for each date of service entered on the claim form.
32	Usual Fee	Enter your usual and customary charge for the service (amount charged to a person who is not a MassHealth member). If you are billing withinan unlisted service code designated IC (individual consideration) in Subchapter 6 of your provider manual, attach a brief report of the service, invoice, or other documentation, and include the provider's usual charge. The payment for an IC service will be determined by MassHealth, based on the descriptive report, invoice, or other documentation of the services furnished. *Monthly rentals for durable medical equipment and oxygen and respiratory therapy equipment:* If billing for a monthly rental in which the actual number of days is less than one month, divide the monthly usual-and-customary fee by the number of days in the month, multiply this by the number of rental days, and enter this amount. *Hospice providers* *For routine home care, general and respite inpatient:* Enter your approved per diem rate for the service. *For continuous home care:* Enter your approved hourly rate for the number of units billed. *Personal Care Agencies* *For functional skills training:* Enter the standard charge per member per month, regardless of the number of skills training sessions provided to the member in the month.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

32	Usual Fee (cont.)	*For initial evaluations:* Enter the provider's usual-and-customary fee. *For reevaluations:* Enter the provider's usual-and-customary fee.
33	Other Paid Amount	Leave this item blank unless the member has other health insurance coverage. Any amount entered here will be deducted from the MassHealth payment.
34	Emerg. Serv.	If emergency services were provided, enter an "X." Attach a report documenting the emergency.
35	Remarks	Leave this item blank unless otherwise noted. *For medications and injectables*: If billing for medications and injectables administered in the office, except vaccines, enter the national drug code (NDC) and the quantity of the drug administered. Use the following qualifiers when reporting NDC units: GR – gram (for creams, ointments, and bulk powders); ML – milliliter (for liquids, suspensions, solutions, and lotions); UN – unit (for tablets, capsules, suppositories, and powder-filled vials); and F2 – international unit (for example, anti-hemophilia factor). If billing for medical supplies, medications, or injectables that are listed in Subchapter 6 of your provider manual as requiring individual consideration (IC), enter a complete description of the item and the acquisition cost in addition to the quantity dispensed and the NDC, and attach a copy of the supplier's invoice. Invoices submitted with a claim must be dated no more than 18 months before the date of service. One invoice indicating all the items for which payment is requested is acceptable.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

35	Remarks (cont.)	*Durable medical equipment providers:* *For repairs:* If the repair does not require a PA, enter the name of the person who requested the repair, date of request, specific description of equipment malfunction, list of procedures and parts used to complete the repair, the cost of each procedure and part, and the time required to complete the repair. *Hearing instrument specialists:* For earmolds, batteries, accessories, and repairs, list each item or repair individually with its unit cost as listed in the manufacturer's catalog or price list or on the manufacturer's invoice.
36	Total Usual Fee	Leave this item blank.
37	Total Other Paid Amount	Leave this item blank.
38	Authorized Signature	The claim form must be signed by the provider or by the individual designated by the provider or hospital to certify the information entered on the form is correct. Signatures other than handwritten signatures (for example, those stamped, typewritten, or mechanically applied) are acceptable.
39	Billing Date	Enter in MMDDYY format the date on which the claim form is completed. Do not use slashes when entering this date. (For example, enter May 1, 2007, as 050107.) This date cannot be before the last date of service on the form.
40	Adjustment/Resubmittal	If the claim is an adjustment or resubmittal, check the appropriate box. Use the resubmittal option for certain claims over 90 days. Do not make any entry in this item without completing Item 41. For additional information about correcting claims, consult Subchapter 5 of your MassHealth provider manual.

Item-by-Item Instructions for Claim Form No. 9 (cont.)

41	Former Transaction Control No.	When an entry is required in this item, enter the 10-character transaction control number (TCN) assigned to the original claim. The TCN appears on the remittance advice that listed the original claim as paid or denied. This item is required if either of the boxes in Item 40 is checked. **Refer to Part 7 of Subchapter 5 of your MassHealth provider manual before attempting to resubmit or adjust claims. Incorrect use of the TCN may result in denied claims.**
42	For Office Use Only	Leave this item blank.